MEDICAL EXTENSION REPORT

DATE DUE:

DATE

RETURN TO:

CASE NUMBER

MEDICAL EXTENSION BENEFITS DATE

☐ You are receiving Medical Extension Benefits through the date shown above.
You may receive an additional six (6) months of Medical if you report the information requested below. Adult family members may be required to pay a premium in order to continue to receive medical benefits in the second six months of medical extension.

☐ In order to continue to receive Medical Extension Benefits, you must report the information requested below.

Enter "0" in the boxes for the months you did not have income or employment-related child care costs.

	MONTH/YEAR	MONTH/YEAR	MONTH/YEAR	
Earned Income before deductions (Both parents)				
Employment-related Child Care Costs				
FOR OFFICE USE ONLY	TOTAL	TOTAL	TOTAL	AVERAGE COUNTABLE INCOME ÷ 3 =

Does anyone else help pay child care costs? ☐ Yes ☐ No

If yes, who? _____ Monthly amount $ _____

Is a child living with you? ☐ Yes ☐ No If no, enter the date the last child left home _____

Do you or a member of your family now have medical insurance coverage that is new or previously not reported to the department? ☐ Yes ☐ No

Is an adult member of your family pregnant? ☐ Yes ☐ No

IMPORTANT

DATE REQUIRED

Report this information by .....

DATE BENEFITS STOP

If requested information is not received, your Medical will stop on .....

SEE BACK FOR INFORMATION ABOUT TERMINATION OF MEDICAL EXTENSION BENEFITS

MEDICAL EXTENSION TERMINATIONS

YOUR MEDICAL EXTENSION BENEFITS WILL BE TERMINATED AND YOUR COVERAGE WILL END IF:

- You do not provide the information on the front of this form by the twenty-first (21) day of the fourth or seventh month of your extension period,
- You move out of state,
- You have no dependent child in your family unit, or
- You have not paid your required premium.

IF YOU HAVE QUESTIONS about this form, please call your financial worker at the Community Services Office (CSO) listed on the front side of this form.